

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	<p>9. To participate in the Maryland Medical Assistance Program as an EPSDT referred services provider for rental of durable medical equipment not covered under the current State Plan, intermediate alcohol and drug treatment facilities, private duty nursing and other necessary health care services described in section 1905(a) of the Social Security Act, a provider shall:</p> <p style="margin-left: 40px;">a. Gain approval by the EPSDT screening provider every 30 days for continued treatment. This approval must be documented by the EPSDT screening provider and the EPSDT referred services provider in the recipient's medical record; and</p> <p style="margin-left: 40px;">b. Have experience with rendering services to individuals from birth to 21 years.</p> <p>10. To participate in the Maryland Medical Assistance Program as an EPSDT referred services provider for private duty nursing services, a provider shall:</p> <p style="margin-left: 40px;">a. Gain approval by the EPSDT screening provider every 30 days for continued treatment for the first 60 days of treatment and every 90 days after that or as considered necessary by the Department. This approval must be documented by the EPSDT screening provider and the EPSDT referred services provider in the recipient's medical record; and</p> <p style="margin-left: 40px;">b. Have experience with rendering services to individuals from birth to 21 years.</p>

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STATE OF MARYLAND

Program	Limitations
4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	11. To participate in the Maryland Medical Assistance Program as an EPSDT School Health-Related Services or Health-Related Early Intervention Services provider, a provider shall: a. At a minimum, gain annual approval by the multidisciplinary team which develops the recipient's Individualized Family Service Plan, Individualized Education Program, or 504 Written Individualized Plan for continued treatment; and b. Have experience with rendering services to individuals from birth to 21 years.

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Program	Limitations
Services that require Preauthorization	<ol style="list-style-type: none">1. All orthodontic care2. All eye examinations, eyeglasses, and contact lenses3. Hearing Aid Services<ol style="list-style-type: none">A. The following require preauthorization:<ol style="list-style-type: none">(1) Hearing aids;(2) Accessories;(3) Hearing aid repairs necessary after the warranty period; and(4) Auditory brainstem response testing, which will be preauthorized when one of the following criteria is met:<ol style="list-style-type: none">(a) Failure of the child to provide consistent behavioral responses to auditory signals using procedures appropriate for the child's developmental age,(b) Presence of neuromotor involvement or behavioral disorder, or both, which precludes observation of consistent behavioral responses.(c) Failure of the child to respond to test signal intensities appropriate to the child's developmental age using developmentally appropriate test procedures, or

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Program	Limitations
Services that require Preauthorization (Continued)	<p>(d) Presence of inconsistencies in the results of the tests administered during audiological evaluation which suggest, but do not define, a hearing impairment.</p> <p>B. Preauthorization is issued when:</p> <p>(1) Program procedures are met;</p> <p>(2) Program limitations are met; and</p> <p>(3) The provider submits to the Program adequate documentation demonstrating that the service to be preauthorized is necessary and appropriate ("necessary" means directly related to diagnostic, preventive, curative, palliative, or rehabilitative treatment; "appropriate" means an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any services which could be used to the same purpose).</p> <p>C. Preauthorization is valid only for 60 days after the date issued by the Department, and the recipient must be eligible at the time the service is rendered.</p> <p>4. Preauthorization requirements for dental services can be found under Dental Services.</p> <p>5. Diagnosis and treatment services are subject to the preauthorization requirements of other programs.</p>

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Program	Limitations
Services that require Preauthorization (Continued)	<p>6. Durable medical equipment covered only under EPSDT requires preauthorization as specified under 5. - 10., pages 32 E. - F., Attachment 3.1A of the State Plan.</p> <p>7. Intermediate care facility - alcoholic (Type D) services when:</p> <p>A. The recipient is placed in an out-of-state facility. Adequate documentation shall be provided demonstrating that the placement meets one of the conditions as follows:</p> <p>(1) Effective services at an in-state facility are not available;</p> <p>(2) For similar services, an inpatient placement is not currently available in Maryland; or</p> <p>(3) The recipient resides out-of-state and the cost for the out-of-state service is comparable to the cost of similar services in Maryland.</p> <p>B. Services which are determined by Medicare to be ineffective, unsafe, or without proven clinical value are generally presumed to be not medically necessary, but will be preauthorized if the provider can satisfactorily document sufficient medical necessity.</p> <p>8. All other necessary health care services covered under section 1905(a) of the Social Security Act.</p>

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STATE OF MARYLAND

PROGRAM

LIMITATIONS

(Continued)

4. C. Family Planning
services and supplies
for individuals of
child bearing age

4. Family planning services as limited by specific
programs covered in the Maryland State Plan items 1,
2a, 2b, 3, 5, 9, 12a, 17e.

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PROGRAM	LIMITATIONS
(Continued)	
4. C. Family planning services & supplies for individuals of child bearing age	<p>Services must be rendered as follows:</p> <ol style="list-style-type: none">1. Services must be under the direction of a licensed physician.2. All Family Planning Clinics must adhere to nationally recognized Family Planning standards.3. Billing time limitations:<ol style="list-style-type: none">a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<ol style="list-style-type: none">(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.d. A claim which is rejected for payment due to improper completion or incomplete information of individuals under shall be paid only if it is properly completed, 21 years of age, and resubmitted, and received by the Program within treatment of conditions the original 6 month period, or within 60 days of rejection, whichever is later.e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

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Program

Limitations

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Services which are not covered are:

1. Physician services not medically justified;
2. Repealed - effective 8/12/85.
3. Physician inpatient hospital services rendered during any period that is in excess of the length of stay authorized by the Utilization Control Agent;
4. Physician services denied by Medicare as not medically necessary;
5. Services which are investigational or experimental;
6. Autopsies;
7. Physician services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinics;
8. Payment to physicians for specimen collections, except venipuncture;
9. Audiometric tests for the sole purpose of prescribing hearing aids;
10. Immunizations required for travel outside the continental United States;
11. Injections, and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical records;
12. Visits solely to accomplish one or more of the following:
 - (a) Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures;

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STATE OF MARYLAND

PROGRAM

LIMITATIONS

(Continued)

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

- b. Recording of an electrocardiogram;
- c. Ascertaining the patient's weight;
- 13. Interpretation of laboratory tests or panels;
- 14. Medical Assistance prescriptions and injections for for central nervous system stimulants and anorectic agents when used for weight control;
- 15. Drugs and supplies dispensed by the physician which are acquired by the physician at no cost;
- 16. Billing time limitations:
 - a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.
 - b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:
 - (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and
 - (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.
 - c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.
 - d. A claim which is rejected for payment due to improper completion or incomplete information of individuals under shall be paid only if it is

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PROGRAM

LIMITATIONS

(Continued)

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

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~~e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.~~

- B. Pre-operative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultants.
- C. Referrals from one physician to another for treatment of specific patient problems may not be billed as consultations.
- D. The operating surgeon may not bill for the administration of anesthesia or for an assistant surgeon who is not in his employ.
- E. Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
- F. The Department will not pay a provider for those laboratory or x-ray services performed by another facility. The Department will pay directly the facility performing those services.
- G. The Program does not cover services rendered to an inpatient before one pre-operative inpatient day, unless preauthorized by the Program.
- A. The following procedures or services require preauthorization:
1. Cosmetic surgery;

Services that require
preauthorization

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